Hometown Health Plan
Summary of Benefits – State of Nevada
Benefit Plan: 25-1500 A D0000 2010

This document contains summary information for your reference. It does not contain all of the prior authorization requirements and specific restrictions, exclusions and limitations associated with this benefit plan. Refer to the Hometown Health Plan (Hometown Health) HMO Evidence of Coverage (EOC) for a more comprehensive list of prior authorization requirements and specific restrictions, exclusions and limitations.

This Summary of Benefits and the EOC have been amended to comply with the requirements of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010. As of August 3, 2010, the United States Department of Health and Human Services and other regulatory agencies had not issued regulations and guidance with respect to many aspects of these laws. Hometown Health will provide coverage under your benefit plan in accordance with these laws and in compliance with applicable regulations and guidance as they are issued.

Specific terms used throughout the Summary of Benefits are defined as follows:

Benefit plan – the specific health insurance policy outlined in this Summary of Benefits

Copayment – the specific amount payable by the member to a provider of care at the time of service for certain covered services

Out-of-pocket copayment maximums – the maximum payment amount for which the member or family is responsible for copayments in a plan year for certain covered services

Prior authorization – a determination of medical necessity and benefit coverage using Utilization Management and Quality Assurance protocols prior to the services being rendered

Participating providers – a physician, medical group, hospital, skilled nursing facility, home health agency or any other licensed institution or health professional who is listed in the current Hometown Health Directory and who is under contract with Hometown Health to provide covered services to members

The benefits outlined in the Benefit Summary Table are not a complete listing of the medical services covered under this benefit plan. Benefits for services not listed can be found in the EOC. Copayments for services not shown in the Benefit Summary Table are determined by the location in which services are provided (such as emergency rooms, urgent care centers or physicians' offices). The copayment amounts listed in the Benefit Summary Table are applicable for covered services received as described in the EOC. All charges associated with non-covered services or denied claims are the member's responsibility.

Benefit Category	Member Responsibility
Annual Out-of-Pocket Copayment Maximum –	
Single	$ 6,200
Family	$ 12,400
During any plan year individuals are responsible for paying copayments up to the single annual out-of-pocket copayment maximum unless coverage is extended to qualified dependents. If coverage is extended to qualified dependents, copayments must be paid up to the family annual out-of-pocket maximum.	

Benefit Summary Table (continued)	
Benefit Category	Member Responsibility
Physician Office Visits –	
Primary care (PCP)	$ 25 copay / visit
Obstetrics and gynecology (no referral required)	$ 25 copay / visit
Specialist care (no referral required)	$ 45 copay / visit
Preventive Screenings –	
Mammography screening	no charge
Prostate Specific Antigen (PSA) screen	no charge
Papanicolaou (Pap) test	no charge
Colorectal screening	no charge
Hospital Inpatient Services –	
Acute care hospital	$ 1,500 copay / admit
Outpatient observation	$ 1,500 copay / admit
Skilled nursing facility (limited to 30 days per plan year)	$ 1,500 copay / admit
Rehabilitation facility (limited to 30 days per plan year)	$ 1,500 copay / admit
Inpatient hospital services include a semiprivate room, physician services, meals, operating room charges, imaging services and laboratory service. Inpatient hospital services require prior authorization.	
Urgent Care and Emergency Services –	
Urgent Care Center Services	$ 50 copay / visit
Emergency Room Services (copayment waived if the member is admitted to the hospital)	$ 300 copay / visit
Ambulance (ground)	$ 150 copay / trip
Ambulance (air and water)	$ 200 copay / trip
Imaging and Diagnostic Testing –	
Computer Tomography (CT) scan	$ 250 copay / visit
Positron Emission Tomography (PET) scan	$ 350 copay / visit
Magnetic Resonance Imaging (MRI)	$ 250 copay / visit
General Nuclear Medicine	$ 250 copay / visit
Imaging and Diagnostic Testing –	
Service Provided in a primary care physician office	$ 25 copay / visit
Services provided in a specialty care physician office	$ 45 copay / visit
Service Provided in a hospital outpatient setting	$ 75 copay / test
Diagnostic mammography	$ 45 copay / visit
Laboratory Services –	
General laboratory services	no charge

Benefit Summary Table (continued)	
Benefit Category	Member Responsibility
Outpatient Therapy and Rehabilitation Services –	
Occupational therapy (limited to 30 visits per plan year)	$ 25 copay / visit
Speech therapy (limited to 30 visits per plan year)	$ 25 copay / visit
Physical therapy (limited to 30 visits per plan year)	$ 25 copay / visit
Cardiac & pulmonary rehab. (limited to 40 visits per plan year per type of therapy)	$ 25 copay / visit
Wound therapy in an outpatient hospital setting	$ 75 copay / visit
Chemotherapy in an outpatient hospital setting	$ 75 copay / visit
Chemotherapy in a physician office	$ 50 copay / visit
Infusion therapy in an outpatient hospital setting	$ 75 copay / visit
Infusion therapy in a physician office	$ 50 copay / visit
Home infusion therapy	$50 copay/visit
Radiation therapy outpatient/in a physician office	$ 75 copay / visit
Special pharmaceuticals have a separate patient responsibility. Rehabilitation services require prior authorization.	
Mental Health –	
Inpatient - mental health	$ 1,500 copay / admit
Partial hospitalization	$ 75 copay / day
Autism (limited to $36,000 per plan year)	$ 25 copay / visit
Outpatient - mental health	$ 25 copay / visit
Inpatient mental health, substance abuse, partial hospitalization services require prior authorization. Outpatient mental health, substance abuse, and counseling visits for greater than 12 visits per plan year require prior authorization for benefit coverage.	
Surgical Services –	
Performed in primary care physician's office	$ 25 copay / visit
Performed in specialty care physician's office	$ 45 copay / visit
Performed in outpatient facility	$ 1,000 copay / day
Performed in same-day-surgery facility	$ 1,000 copay / day
Diagnostic & therapeutic endoscopy	$ 150 copay / day
Surgical services performed in an outpatient or same-day-surgery facility require prior authorization. Copayments for services received in an outpatient or same-day-surgery facility apply toward the professional and/or facility charges.	
Medical Supplies –	
Durable medical equipment – purchase or rental (limited to $3,500 per plan year)	no charge
Orthopedic and prosthetic devices (limited to $25,000 per plan year)	$ 25 copay
Ostomy Care supplies	$ 25 copay
Special food products	$ 25 copay
The purchase or rental of durable medical equipment, orthopedic, or prosthetic devices in excess of $250 requires prior authorization. All medical supplies, including oxygen-related equipment, require authorization. Certain supply orders are limited to a 30-day supply.	

Benefit Summary Table (continued)	
Benefit Category	Member Responsibility
Alcohol and Substance Abuse Treatment –	
Inpatient – treatment	$ 1,500 copay / admit
Outpatient – treatment	$ 25 copay / visit
Inpatient mental health, substance abuse, partial hospitalization services require prior authorization. Outpatient mental health, substance abuse, and counseling visits for greater than 12 visits per plan year require prior authorization for benefit coverage.	
Medical Pharmacy and Immunizations –	
Special pharmaceuticals (authorization required for certain drugs)	30% coinsurance
All other medical pharmacy (out of pocket maximum does not apply)	$ 30 copay
A separate plan year out-of –pocket maximum applies ($2,000 for individuals and $6,000 for families) for special pharmaceuticals. Some medications, injections, and infusion drugs require prior authorization.	
Other Medical Services –	
Alternative medicine (limited to $1,000 per plan year)	$ 45 copay / visit
Spinal manipulation (limited to $1,000 per plan year)	$ 45 copay / visit
Home health care	$ 25 copay / visit
Hospice (limited to cumulative 185 inpatient days or visits)	no charge
Kidney dialysis and associated services	$ 45 copay / visit
Genetic Counseling and testing	Copayment varies by site of service

Other Benefit Information –

Notwithstanding anything in this Summary of Benefits to the contrary, the annual limit on the dollar value of benefits for any individual on benefits that are "essential health benefits" (as defined by the Secretary of the U.S. Department of Health and Human Services) will be no less than the applicable annual limit for the policy year as set forth in regulations promulgated by the Secretary of the U.S. Department of Health and Human Services.

This is an open access plan which means Hometown Health Plan (HMO) members may self-refer to select specialists contracted with Hometown Health Plan (HMO) without first obtaining a referral from a Primary Care Physician (PCP). Certain services require the member to receive prior authorization from Hometown Health prior to receiving the service. If prior authorization for these services is not received, the member may be responsible for payments related to the unauthorized services that the member received. Refer to the Utilization Management Program, Certification and Prior Authorization sections, in the EOC for a more comprehensive list of services requiring prior authorization.

Notwithstanding anything in this Summary of Benefits to the contrary, Hometown Health will provide:

1. emergency services (as defined within the EOC) without requiring a prior authorization and with the same cost sharing requirement with respect to in-network and out-of-network providers and with respect to providers for which Hometown Health has no contractual relationship, and
2. preventive services described in the Public Health Service Act, Section 2713(a) (as amended by the Patient Protection and Affordable Care Act) without any cost sharing requirements.

The benefits described in this document and the EOC are available only when services are provided by a participating provider, unless referred by a Primary Care Physician and authorized in advance by Hometown Health. Prior authorization from Hometown Health is required for all services except those services provided by a member's Primary Care Physician unless otherwise noted.

Exclusions

The following services and benefits are excluded from coverage unless otherwise covered through a benefit rider purchased in connection with this benefit plan or incorporated into the plan of benefits described in your EOC and this plan specific Summary of Benefits.

1. Services of non-participating providers; except in an emergency or urgently needed services or unless prior-authorized by Hometown Health
2. Services not medically necessary or not required in accordance with accepted standards of medical practice (Screening and prevention procedures for disease not specifically endorsed and recommended by the U.S. Health Preventive Services Task Force for the member's specific age group or other specified criteria.)
3. Services not medically necessary or not required in accordance with accepted standards of medical practice or applicable law
4. Any injury or illness that arises out of or in the course of any employment for pay or profit
5. Charges for care or services provided before the effective date or after the termination of coverage
6. Any loss, expenses, or charges resulting from the member's participation in a riot or criminal act (including the commission of or attempt to commit a felony or to which a contributing cause was the member's being engaged in an illegal occupation); and losses related to an act of war, insurrection, or terrorism
7. Testing and treatment for educational disorders, non-medical ancillary services such as vocational rehabilitation, work hardening programs, and employment training and counseling, including services rendered by or billed by a school or member of its staff
8. Care for military service-connected disabilities and conditions for which the member is legally eligible to receive from governmental agencies and for which facilities are reasonably accessible to the member
9. Care for conditions that federal, state or local law requires be treated in a public facility, care provided under federally or state funded health care programs (except the Medicaid program), care required by a public entity, care for which there would not normally be a charge
10. Routine examinations primarily for insurance, immigration, travel, licensing, school sports, adoption purposes, employment, and other third-party physicals
11. Immunizations related to foreign travel or employment
12. Expenses for medical reports, including presentation and preparation
13. Examinations for court-ordered treatment, or in connection with legal processing (Laboratory and other diagnostic testing provided in connection with this exclusion are also excluded.)
14. Medical and psychiatric evaluations, psychological testing, therapy, and other services including hospitalizations or partial hospitalizations that are ordered as a condition of processing, parole, or probation (Laboratory and other diagnostic testing provided in connection with this exclusion are also excluded.)
15. Cosmetic surgery or medical procedures, defined as any plastic or reconstructive surgery, or medical procedures done primarily to improve the appearance of any portion of the body

    Excluded cosmetic services or procedures are further defined as:

- Cosmetic surgery exclusions including but not limited to surgery for sagging or extra skin; any augmentation or reduction procedures; electrolysis; liposuction; liposculpting; body contouring or recontouring to remove excess skin on any part of the body including but not limited to: tummy tucks, belt lipectomies, breast reductions or lifts
- Cosmetic laser treatments; rhinoplasty and associated surgery; epikeratophakia surgery; kerato-refractive eye surgery including but not limited to implants for correction of presbyopia, correction of facial or breast asymmetry (except breast asymmetry will be provided pursuant to coverage as provided in this Summary of Benefits or your EOC for mastectomy benefits), treatment of male-pattern baldness, electrolysis, waxing or other methods of hair removal, or hair treatment, keloid scar therapy, any procedures utilizing an implant which cannot be expected to substantially alter physiologic functions are additionally not covered under this Summary of Benefits and your EOC
- Cosmetics, dietary supplements, anti-aging treatments (even if approved by the FDA for other clinical indications), vitamins, diet pills, health or beauty aids, vitamin B-12 injections (except for pernicious anemia, other specified megaloblastic anemias not elsewhere classified, anemias due to disorders of glutathione metabolism, post surgery care or other b-complex deficiencies), antihemophilic factors including tissue plasminogen activator (TPA), acne preparations, and laxatives (except as otherwise covered and described within this Summary of Benefits and your EOC)

Additional cosmetic surgery or medical procedures exclusions include:

- Complications resulting from excluded cosmetic surgery
- Complications of medical procedures that result in conditions that affect the appearance of the body without commensurate impairment of bodily function
- Cosmetic treatment or service related complications, insertion, removal or revision of breast implants (including complications) unless provided post mastectomy
- Psychological and physical factors including but not limited to self-image, difficult social or peer relations, embarrassment in social situations, inability to exercise or participate in recreational activities comfortably, or impact on ability to perform one's job duties
- Charges which result from appetite control, food addictions, eating disorders (except documented cases of bulimia or anorexia that meet standard diagnostic criteria as determined by Hometown Health and present significant symptomatic medical problems) or any treatment of obesity

16. Treatment of benign skin lesions that consist of destruction or removal by any surgical technique

    Examples of benign skin lesions are capillary hemangiomas (port wine stains), cavernous hemangiomas, dermatofibromas, warts (verruca vulgaris), keloids, skin tags (acrochordon), epidermal inclusion cysts, sebaceous cysts, or benign nevi.

17. Special formulas, food supplements or special diets including but not limited to total parenteral nutrition (TPN) except for acute episodes and as otherwise set forth in this Summary of Benefits and your EOC

18. Any procedure or treatment designed to alter physical characteristics of the member to those of the opposite sex; and any other services, treatments, drugs, or diagnostic procedures or studies related to sex transformations

19. Treatment for the removal, ablation, injection, or destruction of varicose veins
20. Chronic pain therapy and treatment for chronic pain
21. Spinal manipulation for chronic or recurring conditions
22. Non-symptomatic foot care such as the removal of warts (except plantar warts); corns or calluses; and including but not limited to podiatry treatment of bunions, toenails, flat feet, fallen arches, and chronic foot strain
23. Routine foot care
24. Surgical or invasive treatment for obesity or morbid obesity including but not limited to gastric restrictive services; reversals and complications, unless medically necessary and covered as described within this Summary of Benefits and your EOC
25. All experimental or investigational medical, surgical or other health care procedures and all transplants except as otherwise described within this Summary of Benefits and your EOC
26. Custodial, domiciliary care or homemaker services
27. In home services provided by Certified Nurse Aides or Home Health Aides
28. Any services or supplies furnished in an institution that is primarily a place of rest, a place for the aged, a custodial facility, or any similar institution
29. Travel, accommodations, and oxygen provided while traveling on an airline
30. Any services received outside the United States unless deemed to be urgent or emergent
31. Personal, beautification, or comfort items for while in a hospital or skilled nursing facility
32. Private duty nursing and private rooms in an inpatient setting
33. Penile implants and injectable services and supplies related to the treatment of impotence, including services for the treatment of sexual dysfunction and enhancement medications
34. DME as well as related supplies and consumables including, but not limited to: dressings, any equipment or supply to condition the air, appliances, ambulatory apparatus, arch supports, support stockings, corrective footwear, orthotics or other supportive devices for the feet, heating pads, personal hygiene, comfort, care, convenience or beautification items, deluxe equipment, cochlear implants, and any other primarily non-medical equipment, except as otherwise covered and described within this Summary of Benefits and your EOC
35. Barrier free and other home modifications
36. Prosthetic and orthopedic devices except as otherwise covered and described within this Summary of Benefits and your EOC
37. The fitting and cost of hearing aids including both surgical implanted bone conduction hearing aids and externally worn hearing aids regardless of the etiology of the deafness
38. The promotion of fertility including, but not limited to fertility testing (except as otherwise covered and described within this Summary of Benefits and your EOC); serial ultrasounds; services to reverse voluntary surgically-induced infertility; reversal of surgical sterilization; any service, supply, or drug used in conjunction with or for the purpose of an artificially induced pregnancy, artificial insemination (including

test-tube fertilization); the cost of donor sperm or eggs; in-vitro fertilization and embryo transfer or any artificial reproduction technology or the freezing of sperm or eggs or storage costs for frozen sperm, eggs, or embryos; maternity services related to a member serving in the capacity of a surrogate mother or prescription (infertility) drugs; or GIFT or ZIFT procedures, low tubal transfers, or donor egg retrieval

39. Amniocentesis (except when done in the last trimester for the purpose of determining fetal lung maturity) in the first 16 weeks for genetic testing for the purpose of determining the need for fetal therapy or to determine a medically necessary intervention for the mother
40. Non-newborn circumcisions after 8 weeks of age unless medically necessary and prior-authorized by Hometown Health
41. Termination of pregnancy other than medically indicated abortions necessary to save the life of the mother
42. Long-term physical therapy and long-term rehabilitative services for acute conditions evolving into conditions present after 90 days or for chronic conditions unless an acute event has aggravated the chronic condition
43. Charges for cognitive therapy unless related to short term services necessitated by a catastrophic neurological event to restore functioning for activities of daily living
44. Services related to job, vocational retraining or community re-entry
45. Sleep therapy (except for central or obstructive apnea when medically necessary as ordered by a member's PCP and prior-authorized by Hometown Health), behavioral training or therapy, milieu therapy, biofeedback, behavior modification, sensitivity training, hypnosis, electro hypnosis, electrosleep therapy, electronarcosis, massage therapy or gene therapy
46. Organ transplant services defined as but not limited to:
    - Services of a member where the member serves as the organ donor
    - Transplants utilizing any animal organs
    - Any transportation of the donor (as opposed to transportation of the donor organ only)
    - Any expenses associated with an organ transplant where an alternative remedy is available
    - Any human organ transplant not covered or described within this Summary of Benefits and your EOC, or transplants which, consist of the installation of a non-human device or artificial organ
    - Any expenses for transportation, lodging, and meals for services associated with the transplant including evaluations and the transplant and post transplant periods for the donor, donor's family, recipient, or recipient's family
47. Kidney dialysis or artificial kidney treatments when covered by the Medicare program or other federal or state programs, other than the Medicaid program
48. Tissue transplants (whether natural or artificial replacement materials or devices are used) or oral implants, including the treatment for complications arising from tissue or organ transplants or replacement unless covered and described within this Summary of Benefits and your EOC
49. Therapies, psychological services, counseling or tutoring services for developmental delay or learning disability

50. Treatment of mental retardation, Down Syndrome, and autism (unless covered and described within this Summary of Benefits and your EOC) for which a federal or state law mandates that coverage be provided and paid for by a school district or other governmental agency
51. Care or treatment of chronic marital or family problems, occupational, religious, or other social maladjustments, chronic behavior disorders, chronic situational reactions and hypnotherapy
52. Birth control drugs, devices and implants except as set forth in a prescription drug rider or in this Summary of Benefits and your EOC
53. Prescription drugs except as otherwise set forth in this Summary of Benefits and your EOC or in a prescription drug rider

    Exclusions for prescription drugs include but are not limited to:

    a. Over-the-counter drugs
    b. Medicines and other substances not requiring a prescription even if ordered by a physician
    c. Drugs consumed in a physician's office other than immunizations, allergy serum, and chemotherapy drugs
    d. Self-injectable drugs are not covered except as otherwise covered and described within this Summary of Benefit and your EOC
    e. Prescription drugs purchased from outside of the United States except Canadian pharmacies licensed by the Nevada State Board of Pharmacy (Licensed Canadian pharmacies are listed on the Nevada State Board of Pharmacy Web site at www.bop.nv.gov.)
    f. Prescription drugs may be covered under a separately purchased prescription drug rider.

54. Physician services supplies and equipment relating to the administration or monitoring of prescription drugs unless the prescription drug is a covered benefit or covered in a prescription drug rider
55. Experimental, ecological or environmental medicine including, but not limited to the use of chelation or chelation therapy except for acute arsenic, gold, mercury, or lead poisoning; orthomolecular substances; use of substance of animal, vegetable, chemical or mineral origin not specifically approved by the FDA as effective for such treatment; electrodiagnosis; Hahnemannian dilution and succussion; magnetically energized geometric patterns, replacement of metal dental fillings, laetrile, and gerovital
56. Natural and herbal remedies that may be purchased without a prescription (over the counter), through a Web site, at a physician or chiropractor's office or at a retail location
57. Charges related to the acquisition or use of medical marijuana
58. Over-the-counter support hose or compression socks even if ordered by a physician (Custom hose that must be measured and made specifically for the patient will be covered only for the treatment of burns or lymphedema.)
59. Dental or medical care including but not limited to treatment to the teeth; extraction of teeth; repair of injured teeth; general dental services; treatment of dental abscesses or granulomas; treatment of gingival tissues (other than for tumors); dental examinations; restoration of the mouth, teeth, or jaws because of injuries from biting, chewing, or accidents; artificial implanted devices; braces; periodontal care or surgery; teeth prosthetics and bone grafts regardless of etiology of the disease process; repairs and restorations

appliances that are medically necessary to stabilize or repair sound and natural teeth after an injury as described within this Summary of Benefits and your EOC; other supplies and services including but not limited to cosmetic restorations, implants, cosmetic replacements of serviceable restorations, and materials (such as precious metals)

Exclusions apply even if the condition is due to a genetic, congenital, or acquired characteristic.

60. Dental and or medical care including mandibular or maxillary surgery, orthodontia treatment, oral surgery, pre-prosthetic surgery, any procedure involving osteotomy to the jaw, and any other dental product or service except as otherwise covered and described within this Summary of Benefits and your EOC (Exclusions apply even if the condition is due to a genetic, congenital, or acquired characteristic)
61. Treatment to the gums and treatment of pain or infection known or thought to be due to dental or medical cause and in close proximity to the teeth or jaw, braces, bridges, dental plates or other dental orthosis or prosthesis, including the replacement of metal dental fillings
62. Temporomandibular joint syndrome (TMJ) or dysfunction services and supplies (including night guards) except as covered and described within this Summary of Benefits and your EOC
63. Charges for the fitting and cost of visual aids, vision therapy, eye therapy, orthoptics with eye exercise therapies, refractive errors including but not limited to eye exams and surgery done in treating myopia (except for corneal graft); ophthalmological services provided in connection with the testing of visual acuity for the fitting for eyeglasses or contact lenses except as covered and described within this Summary of Benefits and your EOC; eyeglasses or contact lenses (except coverage for the first pair of eyeglasses or contact lenses following cataract surgery); surgical correction of near or far vision inefficiencies such as laser and radial keratotomy (PK)
64. Services for the following clinical trial services:
    a. Any portion of the clinical trial or study that is customarily paid for by a government or a biotechnical, pharmaceutical or medical industry
    b. Coverage for a drug or device described above which is paid for by the manufacturer, distributor or provider of the drug or device
    c. Health care services that are specifically excluded from coverage under Hometown Health, regardless of whether such services are provided under the clinical trial or study
    d. Health care services that are customarily provided by the sponsors of the clinical trial or study free of charge to the member in the trial or study
    e. Extraneous expenses related to the member in the clinical trial or study including but not limited to travel, housing and other expenses that a member may incur
    f. Any expenses incurred by a person who accompanies the member during the clinical trial or study
    g. Any item or service that is provided solely to satisfy a need or desire for data collection or analysis that is not directly related to the clinical management of the member
    h. Any costs for the management of research relating to the clinical trial or study
65. Cryopreservation or storage charges for collection and storage of biologic materials for any purpose

66. Payment for exercising equipment, vibratory equipment, swimming or therapy pools, spas, whirlpools, personal trainers or gym or health club memberships, exercise programs, exercise physiologists
67. Stress reduction therapy, cognitive behavior therapy for sleep disorders
68. Coverage for human growth hormone or equivalent unless specifically covered and described within this Summary of Benefits and your EOC
69. Services related to psychosocial rehabilitation or care received as a custodial inpatient
70. Religious or spiritual counseling

Limitations –

If the provision of covered services provided under this Summary of Benefits and your EOC is delayed or rendered impractical due to circumstances not within the control of Hometown Health including but not limited to a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, disability of significant part of provider's personnel or similar causes, Hometown Health shall make a good faith effort to arrange for an alternative method of providing coverage. In such event, Hometown Health and providers shall render the covered services provided under this Summary of Benefits and your EOC insofar as practical and according to their best judgment; but Hometown Health and its providers shall incur no liability or obligation for delay, or failure to provide or arrange for services if such failure or delay is caused by such an event.